

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-048319

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No.

Primary Registration District No.

Registrar's No.

12005

STATE FILE NUMBER

918
FILED DEC 21 1962

1003

VS 300
Rev. 4/59

1

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13

DATE AMENDED

2

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH

a. COUNTY

b. CITY (If outside corporate limits, give TOWNSHIP only)

OR TOWN

St. Louis

Length of stay in 1b

c. FULL NAME OF (If NOT in hospital, give location)

HOSPITAL OR INSTITUTION

4609 Steffens

Inside Limits

Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE Missouri b. COUNTY

c. CITY

OR TOWN

St. Louis

Inside Limits

Yes ☒ No ☐

d. STREET ADDRESS (If outside, give location)

ADDRESS

4609 Steffens

Reside on Farm

Yes ☐ No ☒3. NAME OF DECEASED
(Type or print)

First

Middle

Last

CARL

FELSER

4. DATE OF DEATH

Month

Day

Year

12-14-1962

5. SEX

Male

6. COLOR OR RACE

White

7. Married ☒ Never Married ☐Widowed ☐ Divorced ☐

8. DATE OF BIRTH

9-23-1879

83

9. AGE (last birthday)

IF UNDER 1 YEAR

Months

Days

IF UNDER 24 HR

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Machinist

10b. KIND OF BUSINESS OR INDUSTRY

Retired

11. BIRTHPLACE (City and state or country)

Austria

12. CITIZEN OF WHAT COUNTRY

U.S.A.

13a. FATHER'S NAME

John Felser

13b. MOTHER'S MAIDEN NAME

Not Known

14. NAME OF HUSBAND OR WIFE

Anna Rechanger Felser

15. WAS DECEASED EVER IN U.S. ARMED FORCES?

(Yes, ☒ No ☐ unknown) (If yes, give ☒ or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

Anna Felser 4609 Steffens 16

18. CAUSE OF DEATH (Enter only one cause per line
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Arterio Sclerotic Heart Disease

Conditions, if any,
which gave rise to
above cause (a),
stating the under-
lying cause last.

DUE TO (b)

Generalized Arterio-Sclerosis

DUE TO (c)

4200

INTERVAL BETWEEN
ONSET AND DEATHPART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal
disease condition given in PART I (a)PART III. If deceased was female was
there a pregnancy in last 90 days.☐ Yes ☐ No ☐ Unknown19. WAS AUTOPSY
PERFORMED?
YES ☐ NO ☒20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY

Hour

Month, Day, Year

a.m.

p.m.

20d. INJURY OCCURRED
WHILE AT WORK ☐
NOT WHILE AT WORK ☐20e. PLACE OF INJURY (e.g., in or about home,
farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION

COUNTY

STATE

21. I attended the deceased from

5/29/62

to Dec. 13

and last saw her alive on 12/14/62

Death occurred at

5/20 A.M.

on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE

(Degree or title)

W. Hagenbach

22b. ADDRESS

4717 Morganford

22c. DATE SIGNED

12/14/62

23a. BURIAL, CREMATION,
REMOVAL (Specify)

23b. DATE

12-17-1962

23c. NAME OF CEMETERY OR CREMATORY

Missouri Crematory

23d. LOCATION (City, town, or county)

St. Louis Mo.

24. FUNERAL DIRECTOR

ADDRESS

WINGBERMUEHLE 3819 So Grand Blvd

25. DATE RECD. BY LOCAL REG.

DEC 14 1962

26. REGISTRAR'S SIGNATURE

Earl Smith. M.D.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed _____

Licensed Embalmer No. _____

P. O. Address _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.